



State of Utah
Department of Workforce Services
APPLICATION FOR ADDITIONAL PERSONS

Date
Received

Complete this application to apply for assistance for someone who has joined your household. You will be notified of any changes to your case. Total number of people you want to add to your case: _____

1.

Case Name:	SS#:	Case #:
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2. Fill in the boxes below with information about ALL the people you would like to add to your case.

You must give the Social Security Number (SSN) for all household members. This is required under the Food Stamp Act of 1977 by P.L. 997-98. The SSN will be used to check the identity of household members, to prevent duplicate participation and to facilitate mass changes.

	Last Name, First Name, Middle Initial	How Related	Social Security No. ----- Medicare Number	Birth Date	A g e	S e x	U.S. Citizen Yes or No	Marital Status	School/ Training	D E P
									Grade Completed?	
1	Date moved in?								Currently Attending? Yes No Where?	
									Grade Completed?	
2	Date moved in?								Currently Attending? Yes No Where?	
									Grade Completed?	
3	Date moved in?								Currently Attending? Yes No Where?	
									Grade Completed?	
4	Date moved in?								Currently Attending? Yes No Where?	

3. Please answer these questions if the person joining your household is NOT a U.S. citizen.

Emergency Medical Services will NOT be denied due to citizenship status.

Name	Alien #	Entry Date	Country of Origin	Sponsor or Resettlement Agency	R E F I
Status <input type="checkbox"/> Refugee <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Temporary Resident with Amnesty <input type="checkbox"/> Other					

Name	Alien #	Entry Date	Country of Origin	Sponsor or Resettlement Agency	R E F I
Status <input type="checkbox"/> Refugee <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Temporary Resident with Amnesty <input type="checkbox"/> Other					

4. Is the person(s) you are adding to your case pregnant? (Medical proof of pregnancy will be required)..... ☐ Yes ☐ No

Name	Expected Date of Birth
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5. Is the person(s) you are adding to your case known by another name, such as a maiden name or former married name?..... ☐ Yes ☐ No

Current Name	Other Last Name	First Name
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6. Does the person(s) you are adding to your case intend to make his or her home in Utah?..... ☐ Yes ☐ No

7. A. Has the person(s) you are adding to your case applied for/received financial or medical assistance or Food Stamp assistance in the past 12 months?..... ☐ Yes ☐ No

Name	Where?	Type of Assistance	When?
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B. Is the person(s) you are adding to your case now disqualified from the Food Stamp program for providing incorrect information?..... ☐ Yes ☐ No

If yes, which person and in what state: _____

8. Does the person(s) being added to your case (including children) have any of the items listed below?.....☐Yes ☐No
 Does this person(s) have their name on account or property belonging to someone else?.....☐Yes ☐No
☐ **SaVings Account** ☐ **Personal Checking Account** ☐ **Trust Fund (TF/TM/TR)** ☐ **Credit Union Account**
☐ **Cash** ☐ **Time Certificates** ☐ **Stocks/Bonds** ☐ **IRA/KEOGH/401K**
☐ **IIM Account (Tribal oil/gas monies)** ☐ **Money Market Certificates** ☐ **Other**

Name of Financial Institution	Account Number	Joint? Yes/No	Type of Account	Owner/Joint Owners	Amount	Ver	F I A C

9. Does the person(s) being added to your case own any of the types of vehicles listed below?.....☐Yes ☐No
☐ **CAr** ☐ **Snow Mobile** ☐ **Motor Cycle** ☐ **Other Vehicle** (dune buggy, ATV, etc.)
☐ **TrucK/Van** ☐ **Motor Home** ☐ **BoaTs/Motors**

Type of Vehicle	Make	Model	Year	Licensed Yes/No Lic. #	Owner/Joint Owners	Use	Amount Owed	Current Value	Ver	V E H I

10. Does the person(s) being added to your case own, or is anyone buying, any of the types of property listed below?.....☐Yes ☐No
INCLUDE PROPERTY CO-OWNED WITH SOMEONE NOT LIVING WITH YOU
☐ **Home You Live In (Exempt)** ☐ **Camper/Trailer** ☐ **LiFe Insurance (LF/LI)** ☐ **Other Homes**
☐ **Notes or Contracts (NC/NO)** ☐ **Time Share Condos** ☐ **Burial Plans/Cemetery Plots (BS/BC)**
☐ **Rental Property** ☐ **Livestock/Horses (LC/LX)** ☐ **Life Estates/Life Leases**
☐ **Land/Mineral Rights** ☐ **Oil or Gas Leases** ☐ **Tools/Equipment/Inventory**
☐ **Funeral Plan/Burial Contract** ☐ **Other**

Type of Property	Owner/Joint Owners	Joint? Yes/No	Face/Market Value	Equity/Cash Value	Ver	O T A S

11. Does the person(s) being added to your case receive educational benefits from any of these sources?.....☐Yes ☐No
☐ **Scholarships (BI/OF/ON)** ☐ **V.A. Educational Benefits** ☐ **other Educational Grants and Loans (OD/OE/OF/ON)**
☐ **PELL/BEOG** ☐ **SEOG** ☐ **SSIG (ST)** ☐ **NDSL**
☐ **Other (include family, work study, church, employer, etc.)**

Name		Major	Credit Hours	Name		Major	Credit Hours	U N I E
Name of School			Expected Date of Graduation	Name of School			Expected Date of Graduation	
Type of Grant or Loan	Date Applied for or Received	Time Period Covered	Amount	Type of Grant or Loan	Date Applied for or Received	Time Period Covered	Amount	
			\$				\$	
			\$				\$	
			\$				\$	

12. Does the person(s) being added to your case receive any of these types of UNEARNED INCOME?.....☐Yes ☐No
- ☐ Social Security ☐ Unemployment Insurance (UC) ☐ Civil Service Annuity ☐ Church Assistance (CC/IK)
☐ Railroad Retirement ☐ Tribal Funds (OC) ☐ SSI ☐ Workman's Compensation
☐ Cash Gifts (CC) ☐ Child Support ☐ Veteran's Benefits ☐ Pension (CV/RT)
☐ Alimony ☐ Lump Sum Payments ☐ Other

Are any deductions being withheld from these benefits (child support, taxes, health insurance, overpayments, etc)? ☐Yes ☐No
 Explain: _____

Name	Type of Unearned Income\ Claim Number	Denied Yes/No	Amount		Date Applied/ Received	Date Benefits Will Begin	U N I N
			\$	per			
			\$	per			
			&	per			

13. Does the person(s) being added to your case pay alimony or child support AND is the spouse or parent of a disabled person? ?.....☐Yes ☐No
 If yes, provide receipt.
14. Is the person(s) being added to your case a child or sibling of a disabled person?.....☐Yes ☐No
 If yes, does this non-disabled person have income?.....☐Yes ☐No
 If yes, please declare below on question #12 and 15.
15. Has the person(s) being added to your case, or will he or she, receive income this month from a job?.....☐Yes ☐No
 Employment information (including self-employment) - YOU WILL BE ASKED TO VERIFY THIS INCOME.
 List Self Employment expenses:

NAME					NAME				
Is this a temporary job?	If yes, how long will it last?		What is your hourly wage?		Is this a temporary job?	If yes, how long will it last?		What is your hourly wage?	
How often Paid? (circle one): 2X monthly Every 2 weeks Monthly Weekly Daily Hourly Other					How often Paid? (Circle one): 2X monthly Every 2 weeks Monthly Weekly Daily Hourly Other				
Name of Employer (Employer may be contacted), Address and Phone Number					Name of Employer (Employer may be contacted), Address and Phone Number				
Date Started		Average Hours Worked per Week		Day of Month/Wk Paid	Date Started		Average Hours Worked per Week		Day of Month/Wk Paid
Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.	Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.

16. Does the person(s) being added to your case pay out child support?.....☐Yes ☐No
 If yes, how much per month? _____

17. Does the person(s) you are adding to your case want help with bills for medical care received in the last 3 months?.....☐Yes ☐No

Name	Date of Service	Retro-medical Date

AVOID PROBLEMS! You can avoid serious problems by making sure you know your rights and responsibilities and the rules for public assistance. Please read the statements below carefully. If you do not understand something, ask your worker about it. Make sure you understand everything before you sign this application form.

- ALL THE MEMBERS OF MY HOUSEHOLD WILL OBEY FOOD STAMP (IFS APPLYING FOR FOOD STAMPS) AND FINANCIAL ASSISTANCE (IF APPLYING FOR FINANCIAL) PROGRAM RULES. WE WILL NOT LIE OR HIDE INFORMATION. WE WILL NOT GIVE FOOD STAMPS TO ANYONE WHO HAS NO RIGHT TO USE THEM. WE WILL NOT USE FOOD STAMPS TO BUY INELIGIBLE ITEMS. WE WILL NOT USE ANYONE ELSE'S FOOD STAMPS UNLESS WE ARE THEIR AUTHORIZED REPRESENTATIVE. IF WE BREAK ANY OF THESE RULES, WE MAY NOT BE ALLOWED TO HAVE FOOD STAMPS OR FINANCIAL ASSISTANCE. THE FIRST TIME, WE MAY NOT BE ALLOWED TO HAVE THESE BENEFITS FOR 6 MONTHS. THE SECOND TIME, WE MAY BE INELIGIBLE FOR 12 MONTHS. THE THIRD TIME, WE MAY BE PERMANENTLY DISQUALIFIED FROM THE FOOD STAMP OR FINANCIAL ASSISTANCE PROGRAM. WE MAY ALSO BE FINED UP TO \$250,000 OR PUT IN JAIL UP TO 20 YEARS. WE MAY ALSO BE PROSECUTED UNDER OTHER LAWS. A COURT CAN ALSO ORDER AN INDIVIDUAL OFF THE PROGRAM FOR AN ADDITIONAL 18 MONTHS. IF I USE FOOD STAMPS TO BUY OR SELL CONTROLLED SUBSTANCES (ILLEGAL DRUGS OR CERTAIN DRUGS FOR WHICH A DOCTOR'S PRESCRIPTION IS REQUIRED) I CAN BE DISQUALIFIED FROM THE FOOD STAMP PROGRAM. 12 MONTHS FOR THE 1ST OFFENSE AND PERMANENTLY FOR THE SECOND OFFENSE. IF I USE FOOD STAMPS TO BUY OR SELL FIREARMS, AMMUNITION, OR EXPLOSIVES I CAN BE DISQUALIFIED FOR THE FOOD STAMP PROGRAM PERMANENTLY.
- I have received a brochure called "Rights and Responsibilities." I will read this brochure. If I do not understand anything in the brochure, I will ask a worker to explain it to me.
- I am responsible for reporting transferring assets and lump sum receipts. Examples of Lump Sum income include: Insurance settlements, back payments owed to me from Social Security, wages, severance pay; payments in the nature of a windfall such as inheritance, lottery winnings, personal injury awards and Workman's Compensation. (There are special rules concerning Lump Sum income. Contact your worker for explanation of how this may effect your future eligibility.)
- I understand that household members not federally exempt will be registered for work.
- Under penalty of perjury, all household members are U.S. citizens or aliens in lawful immigration status.
- If I apply for financial and Food Stamp benefits on the same application, my Food Stamps may be reduced after approval of financial benefits. I will receive NO advance notice if this happens.
- In consideration of Medical Assistance, I assign to the Utah Department of Health all my rights to medical benefits. I authorize payment of the benefits directly to the Department of Health. If the Utah Department of Health pays for my medical care, I will give them any money I collect from an insurance policy. I will also give them any money I collect from someone liable for my medical expenses. I agree to hold harmless any person or organization making payment to the Department of Health because of this agreement.
- Upon approval of medical assistance, I give any and all of my rights to medical support to the Department of Human Services. I agree to cooperate with the Department of Human Services to establish and collect alimony and child support for my family.
- Any person or organization with information about my health or the health of my family may release that information to the Department of Health and a health care provider.
- The Department of Workforce Services and the Department of Health may release information about my medical eligibility status to health care providers.
- I understand financial assistance for most families is time-limited to a total of 36 months, beginning January 1, 1997. Additional months may be approved if I have a history of working part-time (80 hours a month) while receiving financial assistance or if I have been certified as medically unable to work. The 36 month time limit does not apply when all parents in a household receive SSI assistance or when assistance is being provided to children living with a relative who is not included in the financial assistance.
- I understand that as a condition of receiving public assistance I have automatically transferred to the Office of Recovery Services, all monies payable to me or my child(ren) for any person as support, alimony or medical support. The monies include the amount past due or to become due me or my child(ren). I further understand that anyone may deliver to the Office of Recovery Services, all drafts, checks, money order or other negotiable instruments due by any person obligated to provide support. The Office of Recovery Services has the power of attorney to act in my name endorsing and cashing all drafts, checks, money orders or other negotiable instruments received by the Department as support payments.
- ANY AND ALL ELEMENTS OF ELIGIBILITY LISTED ON THIS FORM MAY BE VERIFIED by the Federal Government, the State of Utah, the Department of Workforce Services, the Department of Human Services, Immigration Naturalization Services, or the Department of Health.

I, _____, read or had read to me the statements above. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are true and correct. I am the person represented by the signature on this document. I understand that any false information on this application will result in prosecution for fraud. I understand that I may request a fair hearing if I disagree with the decision made on this application.

Signature or Mark of the Applicant

Signature or Mark of the Spouse

Signature of Authorized Representative
(FS Only)

Worker:

Worker
#:

Date of Interview:

"The Food Stamp Program is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex, disability, political beliefs, or religion, write immediately to the Secretary of Agriculture, Washington, DC 20250."

Equal Opportunity Employer Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.